BlueCross BlueShield Federal Employee Program.

RITUXAN HYCELA
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Rituxan Hycela

(rituximab and hyaluronidase human)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. What is the patient's diagnosis?

❑Chronic Lymphocytic Leukemia (CLL)

a. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Will this medication be used in combination with fludarabine and cyclophosphamide (FC)? ❑Yes ❑No

ii. Has the patient received at least one full dose of a rituximab product by intravenous infusion? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

i. Has the patient experienced disease progression or unacceptable toxicity while on the requested therapy? ❑Yes ❑No

❑Diffuse large B-cell lymphoma

a. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Will this medication be used in combination with cyclophosphamide, doxorubicin, vincristine, prednisone (CHOP) or other anthracycline-based chemotherapy regimens? ❑Yes ❑No

ii. Has the patient received at least one full dose of a rituximab product by intravenous infusion? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

i. Has the patient experienced disease progression or unacceptable toxicity while on the requested therapy? ❑Yes ❑No

❑Follicular lymphoma

a. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Is the patient's follicular lymphoma relapsed or refractory? ❑Yes ❑No

ii. Will this medication be used in combination with first line chemotherapy? ❑Yes ❑No

iii. Is the patient's Follicular lymphoma non-progressing after first-line cyclophosphamide, vincristine, and prednisone (CVP) chemotherapy? ❑Yes ❑No

iv. Has the patient received at least one full dose of a rituximab product by intravenous infusion? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

i. Has the patient experienced disease progression or unacceptable toxicity while on the requested therapy? ❑Yes ❑No

❑Other **(*please specify*):** _____

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL QUESTIONS

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

2. Will the patient be given either live or non-live vaccines while on therapy? ❑Yes***** ❑No vaccines will be administered
   ****If YES***, select one of the following: ❑Live vaccines ❑Non-live vaccines ❑Live and non-live vaccines

3. **If Non-Live Vaccines**: Will non-live vaccines be administered at least 4 weeks prior to a course of the requested therapy? ❑Yes ❑No

4. Does the patient have a history of Hepatitis B infection? ❑Yes***** ❑No
   ****If YES***, does the prescriber agree to monitor for Hepatitis B reactivation? ❑Yes ❑No

5. Does the patient have any severe active infections? ❑Yes ❑No

6. Does the prescriber agree to monitor for signs of progressive multifocal leukoencephalopathy (PML) or severe mucocutaneous reactions? ❑Yes ❑No

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Rituxan Hycela – FEP MD Fax Form Revised 1/1/2024